

Finding Answers

Disparities Research for Change

A Roadmap to Reduce Racial and Ethnic Disparities in Health Care



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Read more about *Finding Answers'* 33 grantee interventions, 11 systematic reviews, and the Roadmap to Reduce Disparities, online at: www.solvingdisparities.org.

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A Roadmap to Reduce Racial and Ethnic Disparities in Health Care

A six-step framework for health care organizations to reduce disparities and foster health equity.

Introduction

In the United States, racial and ethnic minority patients are more likely to receive lower quality care than white patients.¹ Despite efforts by various national agencies, including the Institute of Medicine (IOM) and the Agency for Healthcare Research and Quality (AHRQ) to reduce health disparities, the gap persists.² New evidence-based strategies can help disparities reduction efforts increase their chances of success. Finding Answers: Disparities Research for Change developed The Roadmap to Reduce Disparities, an evidence-based framework for researchers, policy-makers, and organizations implementing interventions to reduce disparities in care.³

Finding Answers, a national program office of the Robert Wood Johnson Foundation (RWJF), has been researching what works—and what doesn't—to eliminate racial and ethnic disparities in health care. Since 2005, Finding Answers has conducted 12 systematic literature reviews and funded 33 innovative research projects. In 2010, Finding Answers became a technical assistance provider for *Aligning Forces for Quality (AF4Q)*, RWJF's signature effort to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities, and provide models for national reform.

The Roadmap can help organizations integrate disparities reduction into all health care quality improvement efforts. It serves as a process that allows organizations to implement equity-focused quality improvement programs simultaneously or in parallel with other efforts. It is designed to allow an organization to develop programs to address disparities based on available resources and to expand as needed. The causes of disparities may vary across regions or patient populations, but the Roadmap offers a comprehensive approach to achieving equity. It involves six steps:

- 1) Link quality and equity
- 2) Create a culture of equity
- 3) Diagnose the disparity
- 4) Design the intervention
- 5) Secure buy-in
- 6) Implement and sustain change

Effective implementation and long-term sustainability are dependent on devoting full attention to all six steps.

In the United States, racial and ethnic minority patients are more likely to receive lower quality care than white patients, and despite efforts to reduce disparities, gaps persist.

¹ 2012 National Healthcare Quality Report: Chapter 3. Agency for Healthcare Research and Quality, 2012. <http://www.ahrq.gov/research/findings/nhqrd/r/nhq12/chap3.html> (accessed June 2014).

² 2012 National Healthcare Quality Report: Chapter 8. Agency for Healthcare Research and Quality, 2012. <http://www.ahrq.gov/research/findings/nhqrd/r/nhq12/chap8.html> (accessed June 2014).

³ Chin MH, Clarke AR, Nocon RS, Casey AA, Goddu AP, Keesecker NM, Cook SC. A roadmap and best practices for organizations to reduce racial and ethnic disparities in health care. *J Gen Intern Med* 2012; 27:992-1000.

STEP 1: Link quality and equity

Quality care, as described by the AHRQ, is “doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results.”⁴ This means high-quality health care is patient/family-centered, effective, efficient, and accessible for all—in other words, it should be equitable. It should be noted that equitable care does not mean that everyone receives the same care. Instead, it means that care aims to achieve optimal outcomes for all groups of patients, even if achieving optimal outcomes means that care differs from person to person, and group to group.

An important concept to understand is that quality improvement efforts, which improve health outcomes overall, do not necessarily decrease gaps in health outcomes. Health care organizations must tailor quality improvements to each patient population and target the root causes of inequities, and incorporate equity into routine quality improvement processes.

Implement basic quality improvement infrastructure

Quality improvement infrastructure forms the foundation for the reduction and elimination of disparities. Basic elements include metrics and goals to monitor improvement, a shared commitment and effort to engage in continuous improvements across all levels of staff, and a process for cyclical improvement that supports ongoing adjustment of care. When these elements of quality improvement are stable, organizations can more easily integrate equitable care into all aspects of quality improvement.

The collection of health care process and demographic variables like race, ethnicity, and language (REL) is vital not only to individual quality improvement efforts to reduce disparities, but also to foster a general awareness of the importance of equitable care. With the introduction of the Patient Protection and Affordable Care Act (ACA), the collection of performance data stratified by REL, as well as insurance, status has been made a priority.

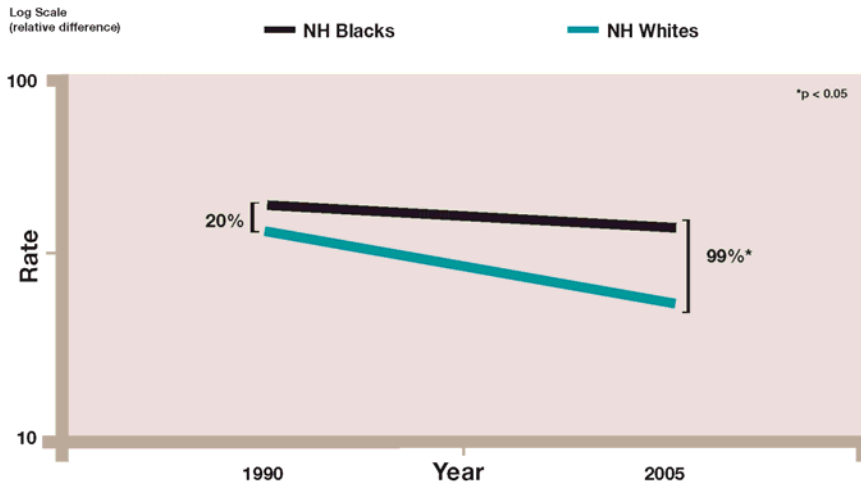
Make equity an integral component of quality improvement

It would seem logical that improving outcomes for every patient would help reduce disparities, just as “a rising tide lifts all boats.” In fact, quality improvement efforts aimed at a general or non-specific population may worsen or even create disparities. For example, between 1990 and 2005, the rate of breast cancer mortality decreased for both non-Hispanic blacks and non-Hispanic whites in Chicago. However, non-Hispanic whites experienced a greater decrease in the rate of breast cancer mortality than non-Hispanic blacks, resulting in a widening gap between white and black patients. (See figure below.)

Not all quality improvement efforts—even those that improve health outcomes overall—reduce disparities.

⁴ *Your guide to choosing quality health care.* Agency for Healthcare Research and Quality, 2003, <http://www.ahrq.gov/consumer/qnt/> (accessed June 2014).

Breast Cancer Mortality Among Non-Hispanic Blacks and Non-Hispanic Whites in Chicago: 1990-2005



Adapted from:
 (Jennifer M. Orsi, Helen Margellos-Anast, and Steven Whitman. "Black-White Health Disparities in the United States and Chicago: A 15-Year Progress Analysis." *American Journal of Public Health*, Vol. 100, No. 2, pp. 349-356, February 2010.)

Efforts to reduce disparities have frequently been conducted separately from efforts to improve quality care. Yet, in the 2010 *Future Directions for the National Healthcare Quality and Disparities Reports*, the Institute of Medicine presented a framework which positioned equity as a cross-cutting dimension of all health care quality components, rather than a single component. In practice, organizations should aim to integrate equity into all routine quality improvement efforts.

STEP 2: Create a culture of equity

Unless specifically measured, disparities in health care can go unnoticed by health care organizations. Stratified data are important to uncover and respond to health care disparities, but it is also important for health care organizations to establish an environment with a strong culture of equity in which all staff and providers recognize disparities and are motivated to address them. Equity should be an integral part of quality improvement efforts—from planning to design and implementation—and this means doing more than simply collecting data.

Creating a culture of equity within an organization is not an easy task. It takes time and commitment from staff and community members. While the process may be long and, at times, difficult, it is important to maintain organizational momentum. During the process of establishing a culture of equity, leaders and staff can implement other steps in the Roadmap. During this process, it is important to remember that the Roadmap can be completed in any order and there is no need to wait until “finishing” a step before moving on to others.

Recognize disparities

Ideally, people at all levels of the health care organization share a common definition of equitable care and value its delivery. Understanding and sharing data are an important first step toward recognizing disparities and establishing a culture of equity. Once collected, stratified quality data should be shared with all of the health care organization’s staff, as well as the organization’s community advisory board.

Identifying disparities through data and training efforts, however, is not sufficient to reduce inequity; efforts need to be accompanied by more intensive approaches to reduce disparities. A Finding Answers grantee, Harvard Vanguard Medical Associates, found that cultural competency training and performance reports of the quality of diabetes care and outcomes, stratified by race and ethnicity, increased providers’ awareness of disparities but did not improve clinical outcomes.⁵ Consequently, cultural competency training and stratified performance data may increase the readiness of providers and organizations to change their behavior, but alone, they are not enough to reduce disparities.

Take responsibility

It is not enough to be aware of disparities issues in a general sense: a robust culture of equity depends on staff and providers recognizing that disparities may exist within a patient population, and taking responsibility for reducing them. It is essential for each individual in an organization to take responsibility for reducing them disparities and improving the quality of care. Every staff member can play a role in disparities reduction, but a culture of equity also depends on widespread commitment to implementing improvements. Facilitating open discussions about documented disparities can help build momentum for the organization’s equity agenda, and encouraging participation by all can help foster an organization-wide culture of equity.

A culture of equity means recognizing that disparities may exist in an organization, and taking responsibility for reducing them.

⁵ Sequist TD, Fitzmaurice GM, Marshall R, Shaeykevich S, Marston A, Safran DG, Ayanian JZ. “Cultural competency training and performance reports to improve diabetes care for black patients: a cluster randomized, controlled trial.” *Ann Intern Med.* 152(1):40-6, 2010.

Open discussions about disparities and plans to improve them often depend on the data to identify those disparities. Unfortunately, many practices feel hindered because they lack REL-stratified data to point out specific disparities in their patient population. In this case, practices should work to collect other information about potential disparities, including qualitative data from patients, via patient advisory councils, focus groups, or regional data, as a temporary proxy for stratified quantitative data.

Below are some examples of actions organizations can take to foster a culture of equity:

- Make sure that equity is explicitly reflected in the organizational mission and vision statements.
- Designate specific leaders who are held accountable for disparities reduction.
- Identify and publicly recognize equity champions, individuals who go the additional distance to promote equity and passionately confront inequalities in care. An equity champion is not a position that someone is specifically hired for, nor does that person need to be part of the leadership team. In fact, it is important to have champions who directly interact with patients and their families.
- Strive to recruit and maintain a diverse workforce that reflects the population you serve.
- Establish and maintain an active community or patient advisory board that is representative of your patient population.
- Develop and maintain strong working and consulting relationships with community-based groups and organizations who serve priority populations.

Creating a culture of equity is not a quick process; it takes time and dedication. However, investing in the establishment of a strong culture of equity will pay off in the long run. The stronger the culture of equity, the more prepared and determined the staff will be to diagnose the specific disparity and design a successful intervention. As we will see, when health care organizations openly declare equity a priority, they create an environment in which staff are most motivated and empowered to appropriately diagnose disparities.

STEP 3: Diagnose the disparity

It may be tempting to jump into designing an equity program once a disparity is identified. Before beginning, however, organizations should take the time to understand why a disparity exists. Disparities can be complicated and their root causes are often not always readily apparent. Analyzing the various possible causes of a disparity will inform the design of the intervention (as we'll explore in Step 4) and will ensure that interventions target causes that are most relevant to the priority population.

Conducting a root cause analysis

A root cause analysis (RCA) is often used in quality improvement to identify the underlying causes of a specific undesirable incident—e.g., what led to a missed screening? In this context, a root cause is a tool to explore a disparity rather than an individual event. When conducting an RCA, identifying the many potential causes of a disparity is most effectively accomplished by gathering a wide variety of perspectives, including those from patients, providers, and staff. Consequently, by forming a diverse team that will meet over the course of several weeks or months to gather information from stakeholders throughout the organization, you can compile the input using standard quality improvement tools. One tool to consider using is the fishbone diagram, which provides a snapshot of the causes of the disparity on a single chart. Using tools makes the causes and effects of the disparities easier to visualize and disseminate throughout the organization.

Applying an equity lens

While conducting the RCA, the team should apply an equity lens, or focus their attention on the issues that are relevant to the priority population and that contribute to the identified difference in care. It is helpful to remember the three Cs—culture, communication, and context. This requires asking questions from the perspective of patients related to the needs of the priority population in order to assess potential barriers to health and health care, such as health literacy or cost, which may be overrepresented among specific minority patients.

Root cause analysis with an equity lens—An extended example

Imagine that a clinic has just examined its process of care measures, stratified by race and ethnicity. The data indicates that black patients with diabetes have much lower rates of foot exams than white patients. Knowing how important foot exams are for monitoring the progression of diabetes, and avoiding serious complications, the clinic gathers a team to investigate the issue—leadership is committed to reducing identified disparities, so they protect staff time for team meetings, and make sure to include front-line providers, staff, as well as patients and members of the community advisory board, on the root cause analysis team.

The first step in applying an equity lens to an identified disparity is to form a question, the answer to which will explain the difference in care or outcomes between populations. In this case, the team agrees to dig into the question “Why do black patients with diabetes have lower rates of foot exams than white patients?”

The team brainstorms and discusses what might cause lower rates of these screening exams. First, staff discuss that local podiatrists' offices fax their reports to the clinic, which are scanned into the electronic medical record (EMR) system. As the reports are scanned

Before designing an equity program, organizations should investigate the root causes of disparities.

in, they don't automatically populate the fields on which the reports are based. Nursing staff suggests that the under-reporting of foot exams may be due to the lack of data in the EMR. This is a general quality improvement issue, and the staff plans to fix the data collection issue, but they realize that it wouldn't explain the disparity; it affects all patients equally.

Next, the team decides to look into the data a little further and notices that there are fewer referrals being given to black patients for foot exams. That would certainly explain why there are fewer foot exams, but to come up with a plan to reduce the disparity, the team needs to go further. They discuss with providers why fewer referrals are being made for black patients. At a lunchtime focus group, providers indicated that—in their experience—black patients were much less likely to utilize the referrals and make an appointment. Now, after the first missed referral, some of the providers indicated that they do not push any further.

Knowing there must be a reason why black patients were less likely to utilize a referral to a podiatrist, the team decided to find out from the patients themselves. At the next patient advisory board meeting, the RCA team asked about podiatrist referrals. They learn that the podiatrists that are being referred are not within walking distance from the clinic; there's only valet parking at the podiatrists' offices, which is very expensive, and the local buses don't have stops close to the offices.

Now, the team has identified a root cause of the issue that they can tackle. The clinic leadership reaches out and establishes relationships with additional podiatrists' offices, which are more conveniently located, and are served better by public transportation. They let providers and patients know about the new options available for referrals—and encourage patients to ask for referrals to the more convenient clinics. They also encourage providers to make new referrals for all of their patients without current foot exams.


In a few months, the team sees a significant improvement in the number of black patients receiving foot exams, and the disparity begins to shrink.

The priority matrix

At the end of the RCA, the root causes of the targeted disparity will be evident, which means the next step is choosing one root cause to prioritize. Using a priority matrix can help determine which causes are most important—and feasible—to address. A priority matrix is a tool to help determine which root causes to target with an intervention. It is a two-by-two square used to compare the feasibility and importance of root causes. An example is included below to demonstrate how the square should be oriented.

A root cause analysis with an equity lens means carefully examining the causes of differences in patient care and outcomes—which may not be immediately obvious.

Which of our root causes are...	Very Important to Address	Less Important to Address
Very Feasible to Address	Fewer referrals: location of podiatrists' office is inconvenient.	Podiatrist offices' fax reports not in EMR
Less Feasible to Address	Patients can't afford specialist copays	Poor access to healthy food



Prioritize tackling these causes

In determining which cause to begin with, it is important to ask two questions:

- How feasible is it to tackle the issue?
- How important is it to tackle the issue?

By evaluating the importance and feasibility of each cause, a decision of which cause to prioritize can be made. It should be noted that it is sometimes best to begin with the low-hanging fruit— an easier, more feasible root cause to address. This will help build momentum in the organization and keep staff motivated to address further root causes. Once the low-hanging fruit has been successfully addressed, consider moving on to more challenging and complex causes.

Here are a handful of common considerations to take into account when assessing feasibility and importance:

- Reach—is a large portion of the priority population affected by this issue?
- Urgency—is prompt/immediate action required?
- Cost—how much funding is needed to address this root cause? Does the issue currently cost the organization a lot of money or staff time?
- Effort—how labor- and time-intensive will it be to address the issue? Is there sufficient staff capacity to support the intervention?
- Readiness and political will—is there momentum and willingness to address this issue?
- Existing resources and infrastructure—are resources already in place that can help address this issue?

STEP 4: Design the intervention

Once organizations have identified the causes most relevant to the priority population and assessed the resources available to implement change, it is time to start designing an intervention.

Organizations should approach planning as a creative and innovative process. During the planning process, evidence-based strategies should be reviewed and incorporated into the equity program. However, due to each organization's unique circumstances, evidence-based strategies should be carefully tailored. Organizations should be cautious of gravitating toward intervention designs that are more familiar. Through the Finding Answers literature reviews, we found that 50 percent of disparity interventions targeted patients, most often with education. Only about 20 percent of interventions targeted providers, the care team, organizations, or health policy.⁶ To support the design of varied and tailored equity interventions, Finding Answers has developed a framework consisting of three building blocks—levels, strategies, and modes.

These building blocks allow for any intervention to be carefully tailored to fit precise circumstances, needs, and goals. Each intervention should be a combination of one level, one strategy, and one mode. This allows for variety in intervention styles and types, and encourages the use of unfamiliar or novel approaches to disparity reduction. The building blocks encourage creativity—step away from what is familiar and create various combinations of levels, strategies and modes to find new ways to approach reducing disparities.

Levels of influence refer to whom the equity activity will target. For example, church-based health education programs reach individuals who may not be part of the traditional health setting; the community is the primary level of impact. A single disparities program can (and often should) target multiple levels. Levels include:

- Patient
- Provider
- Microsystem
- Organization
- Community
- Policy

Strategies are the tactics the organization used in the intervention. For example, the church-based health education program is a strategy to deliver education and training to the larger community. Similar to levels, successful equity interventions often use multiple strategies. Strategies include:

- Deliver the education and training
- Engage the community

Be creative when designing programs. Most published equity interventions target patients; very few target providers, care teams, organizations, or policies.

⁶ Clarke AR, Goddu AP, Nocon RS, et al. "Thirty years of disparities intervention research: what are we doing to close racial and ethnic gaps in health care?" *Med Care*, 51(11):1020-6, 2013.

- Provide psychological support
- Give providers reminders and feedback
- Restructure the care team
- Improve language and literacy services

Mode of delivery captures how the intervention will be implemented. The church-based health education program may rely on print and/or in-person resources, both of which represent modes of delivery of education. Some activities rely heavily on technology while others may use more traditional methods. Modes include:

- In-person or face-to-face meetings
- Telecommunication
- Internet
- Information technology
- Print materials
- Multimedia

Finding Answers identified the various levels, strategies, and modes in the course of reviewing approximately 400 disparities intervention publications. Organizations can also refer to the [Finding Answers Intervention Research \(FAIR\) database](#)—an interactive tool to navigate published disparities interventions by strategy, level, and mode—available on the Finding Answers website as a source of inspiration while tailoring their equity intervention. Likewise, the FAIR Toolkit—flashcards that facilitate creative intervention planning and a detailed portfolio of grantee interventions—is also available on the Finding Answers website (www.SolvingDisparities.org).

Best practices to guide intervention design

Using the FAIR database findings and the lessons learned from the grantees' interventions, Finding Answers has compiled a list of best practices—the vital techniques to include in any intervention aimed at successfully reducing disparities.

When designing an intervention, it is helpful to incorporate some of the already identified best practices. The intervention should target the root causes the organization identified in Step 3. Successful interventions will include a variety of techniques to target levels, strategies, and modes. The following examples demonstrate several of Finding Answers best practices that are particularly relevant to intervention design. (A full table of the best practices can be found in Appendix 1.)

Target multiple levels and players in the care delivery system. As the causes of disparities are complex, solutions need to address multiple factors. Avoid focusing only on patients. Instead, design programs that also intervene with providers, organization, communities, and policies. The more levels the intervention targets, the more likely it is to effectively address the multiple causes of a disparity.

One Finding Answers grantee, Duke University Medical Center, incorporated patients, providers, and the community into their intervention. Nurses received special training in community health, cultural sensitivity and motivational interviewing, while patients enrolled

Target multiple levels and players within the health care system; the causes of disparities are multifaceted, and often, so are the solutions.

in a telephone-based cardiovascular disease risk management program. By including multiple players and levels into their intervention, Duke was able to successfully improve health outcomes and gain respect in the community through successful dissemination of their results via local radio interviews, pamphlets, and wide program implementation by statewide partners.

Appoint staff to disparities reductions initiatives and protect staff time. A plan to improve equity requires human resources. Anticipate leadership and staff turnover by cross-training staff. Consider quality improvement specialists and recognizing on-site equity champions. This will prevent staff from becoming overtaxed and will help them remain committed to the program over time.

The Fund for Public Health New York, another Finding Answer grantee, recognized the need to appoint an equity champion in its organization. A staff member described an equity champion as someone who “often works at the level of nurse or care coordinator and is seeking ways to demonstrate talent beyond his or her prescribed duties. In our experience, the equity champion is self-identified, but it is important that supervisors also approve of their role.” With equity champions, the organization is more motivated to reach their full potential in reducing inequities.

Interventions are more likely to be successful if staff recognizes that disparities exist within the organization. Share feedback with providers, incentivize disparities reduction, and include equitable health care as a goal in mission statements. If staff, patients, and community members share a common definition of equitable care, health care delivery will be more successful.

Grantees Harvard Vanguard Medical Associates and Baylor College of Medicine both successfully implemented a culture of equity in their organizations. Harvard’s Board of Trustees added equity as a main component of their quality improvement strategy, while Baylor opened an Office of Health Equity and hired a chief equity officer. These actions demonstrate that both view equity as a priority and are determined to make it part of their organizational culture.

Involve members of the target population during program planning. Directly engaging patients in the intervention design process is crucial to an equity program’s success. For example, the Neighborhood Health Plan of Rhode Island (NHPRI), a Finding Answers grantee, learned that input from minority health workers cannot serve as a proxy for patient involvement and that cultural targeting is an important factor in ensuring the success of an equity intervention.

NHPRI hired bilingual and Latino depression care managers who contacted patients via the telephone to provide one-on-one follow-up reminders for appointments and self-care, and culturally competent education about depression. Latino patients, however, showed little interest in the program and few chose to participate. After conducting patient focus groups, the team learned that the intervention used up patients’ valuable cell phone minutes. In effect, patients held a different opinion of which mode of delivery would work best than did the Latino staff and providers who had contributed to the design of the intervention.

Strike a balance between adherence and adaptability. While adherence to protocol ensures consistency, flexibility is key when working with diverse patients. Regularly

Incorporate patient input into the planning and design of equity programs; engaging patients from the beginning can be critical to a program’s success.

collecting process measures, identifying opportunities for improvement, and adapting the intervention accordingly will ensure that programs are consistent, yet flexible.

Cooper Green Mercy Hospital's intervention required patients to view a DVD, which was mailed to them, prior to their appointment. After many patients arrived for their appointment without having watched the DVD, Cooper Green realized they needed to adapt their plan. They prepared a small conference room for participants to view the DVD. This ensured the program was consistent with its original aims but flexible enough to fit patients' unique needs.

In addition, successful equity interventions often:

- Use cultural targeting to adapt the intervention for the priority population.
- Are led by nurses or generally use a team-based approach to care delivery.
- Add a patient navigator to the care team or assign a current team member the role of patient navigator.
- Employ an interactive and skills-based, rather than didactic, teaching methodology when delivering education.

STEP 5: Secure buy-in

Buy-in is a concrete pledge to support and provide resources for equity activities and interventions. It represents a practice's engagement and dedication to the intervention. This commitment is demonstrated through action, rather than passive acceptance. Buy-in is necessary from everyone in the practice—from leadership to patients. When implementing an equity program, the general commitment to reducing disparities will be supplemented by concrete support for the specific intervention. Examples of concrete support include leadership budgeting funds to support a program or freeing up resources, such as staffing and meeting time. Patients can demonstrate buy-in by showing up for an extra office visit, while community leaders can do so by providing feedback on the program's design and getting the word out about the program.

Effective messaging

One key to securing concrete support is effective messaging. Effective messaging helps stakeholders find the link between the intervention and their priorities. Furthermore, effective messaging is persuasive because it anticipates concerns. In particular, it addresses why the proposed intervention is better than maintaining the status quo or pursuing a different equity program.

Obtaining buy-in from various stakeholders

Organizations consist of many individuals who are all motivated for different reasons. A staff member working on the front lines will have a very different motivation from someone in a leadership role. It is important to appeal to all stakeholders to ensure buy-in across the entire organization.

Leadership is often concerned with a return on investment, but a return on investment is not necessarily measured in revenue. Leadership dedicates resources to an equity intervention because it helps meet the organization's mission and value objectives. Investing in equity helps the organization comply with regulatory requirements and may make the organization eligible for additional funding sources.

Staff buy-in is key as they are the individuals who will implement the equity intervention. Soliciting feedback from staff members likely to be impacted by the equity intervention will allow all staff to be invested in the program. Additionally, reporting back shows staff members that their input is valued and helps prevent them from disengaging throughout the design, implementation, and evaluation of the intervention.

Olive View-UCLA, a Finding Answers grantee, grappled with the issue of obtaining staff buy-in. To overcome this difficulty, the team held a meeting with front-line staff. They discussed why the project was worth additional time and effort, explained exactly how the project would affect staff workload, and described the steps they had taken to minimize burden. Additionally, they solicited feedback about how best to incorporate the intervention into clinic flow and adjusted the program to address staff concerns. This direct approach was helpful in increasing uptake of the activity and securing buy-in from front-line workers.

For many **patients**, the success of the intervention is impacted by how active the patient is in managing his or her condition. Inspiring active patient participation and thinking carefully about recruitment strategies will help secure patient buy-in. For example, a

Securing buy-in from everyone involved in an equity program is an essential component to that program's results.

Finding Answers grantee at Yale University screened mothers for depression during visits to the pediatrician and encouraged mothers to undergo treatment for the well-being of their children. This messaging was successful because it appealed to the mothers' primary concern.

Giving patients a choice in how the program will work for them also encourages buy-in. A Finding Answers grantee at the University of Southern California had social workers guide patients with depression to choose the treatment they preferred: medication, therapy, or both. They found that patients were more likely to enter care and receive more of the recommended treatment protocol when given this choice.

Community partners can help get the word out about the equity program. The Improving Diabetes Care and Outcomes on the South Side of Chicago project

(<http://www.southsidediabetes.org>)—a multifaceted community-focused initiative to improve diabetes care and outcomes—has years of experience cultivating robust and long-lasting community buy-in. Based on their relationship-building with community health groups, experts from the South Side project suggest⁷:

- **Give before you get.** 'Giving' is about being reciprocal and a team player. Giving may be easier than you think. For example, a free lecture from a medical professional can mean a lot to community organizations. Giving is not just something that happens after people agree to work on your project. Ideally it comes first. Become known in the community—because of your giving—before going to organizations to talk about ways in which they can help advance your agenda.
- **Be interested in other people's agendas.** Take interest in the goals and aims of your partners. You may have an agenda to advance, but so do they. For example, the diabetes project staff once helped a local community group recruit face painters—not because they were experts in face painting, but because it was a genuine need for the group's event, and the project staff knew students who could help.
- **Meet with everyone you want to know, one-on-one, before you meet together as a group.** Individual conversations build personal relationships, and with those relationships come trust. Your potential partners get a better sense of who you are, and it helps people understand how you can serve their interests too.
- **Meet partners where they are.** This tip is important—in two ways. Literally: Meet partners at their office or location; don't always make them come to you. Metaphorically: Work to understand the needs of your partners, and strive to forge a mutually beneficial relationship.
- **Be a constant presence.** Join a partner's team for the long term. Do not just drop in for the projects that help your agenda. For example, volunteer to serve on their committees.
- **Be a champion for resource distribution.** Help deploy your resources whenever possible. Share what you have, and what they need—whether that is space, volunteers, or material resources. Even small donations or loans can make a big difference in a partnership.

Community groups can help get the word out about an equity program, but it's important to cultivate mutually beneficial relationships to ensure robust and long-lasting partnerships.

⁷ Personal communication: Monica Peek, MD, MPH; Anna Goddu, MSc. June 25, 2012.

STEP 6: Implement change

If organizations have analyzed the causes of a targeted disparity, designed a tailored intervention to address the causes most relevant to the patient population, and secured buy-in from all involved stakeholders for the proposed plan of action, then they have laid a strong foundation for success. This is good planning; however, good planning does not always translate to good implementation.

Each organization will have a different readiness to implement change, but organizations can set themselves up for success by following the Roadmap's recommendations. These guidelines provide a strong base of knowledge and support. As staff and patients become more comfortable with the new culture of equity, the implementation of change will become easier, as well.

Start small, measure often, adjust frequently

The best implementation results in a permanent change to the way the work is done and, as such, it may affect several elements of the organization's infrastructure. Testing a change on a small scale, learning from each test, and refining the change through several plan, do, study, and act cycles will help organizations prepare for implementation on a broader scale. This type of cyclical improvement also ensures that efforts are not creating or worsening disparities, as the efforts are constantly being checked and changed accordingly. The cycle of reviewing data and improving processes can help break goals into manageable pieces, ensure accountability, and address feasibility challenges before they compromise the intervention. Additionally, aiming for low-hanging fruits and quick wins will help build momentum.

Pilot testing

Pilot testing helps identify elements of the intervention that work well and elements that may need tweaking. Below are a few tips for pilot testing:

1. Be sure to test the activity with the priority population for which the intervention was designed.
2. Conduct the pilot test with patients and staff who were not involved in earlier planning phases. This will help spread knowledge about the equity program to new parties and get their diverse perspectives.
3. Run tests with a diverse set of patients to identify needs that may differ across populations.

Evaluation

Prior to beginning a quality improvement effort, organizations should define measures that will track their improvements. Organizations should include the measures they used to identify the disparity—often patient outcome data, which can be slow to show change. Organizations should also include measures that can demonstrate the intervention's impact more immediately, like process of care measures. Regular evaluation will ensure that the intervention is not having unintended or negative effects on the practice. Be sure to consistently collect process measures and identify areas that could use improvement. Adhering to protocol ensures consistency, but flexibility is equally as important for

Cyclical improvement lays the groundwork for long-lasting improvements, and can help build momentum for future change.

improvement. When working with diverse groups of patients, be prepared to adapt programs as needed to better fit their unique needs.

Three types of measures are helpful for a successful data evaluation: process, outcome, and intervention tracking measures.

Process measures refer to the process of care delivery. Ideally, organizations will use evidence-based process measures that have been demonstrated to improve patient outcomes (e.g., administering a flu shot). Process measures tend to improve faster than outcome measures, as they focus more on one specific aspect of care rather than clinical outcomes, which are affected by a variety of factors.

Outcome measures refer to the actual results for the patient, including clinical indicators, such as blood pressure control, or hemoglobin A1C for patients with diabetes. Other outcome measures include the number of emergency department visits or hospitalizations among a patient population and patient experience assessed by survey. Don't forget that it takes time to see changes in the disparities outcomes. Early wins will likely be process-oriented.

Intervention tracking measures capture whether the intervention was successfully implemented. Example tracking measures include the number of patients recruited to receive the intervention and the rate at which staff are trained to deploy the intervention. These measures help organizations avoid wasting time or resources as they adopt new intervention approaches. Intervention tracking measures provide information that can help foster successful implementation and can help inform future decisions about staffing, cost, and future sustainability. These data usually come from work plans, staff assignment logs, or other workflow-based sources.

Sustainability

Sustainability is dependent upon a culture of equity within the organization, the integration of disparity activities into quality improvement efforts, and maintaining buy-in from all appropriate stakeholders. It is important to note: Sustainability should not be something that happens after an intervention, but rather, it needs to be carefully incorporated throughout the intervention's design and implementation.

Too often interventions are dependent upon an initial champion and the first burst of enthusiasm. If an equity champion leaves the organization, or if the staff tires after the early stages of implementation, disparities initiatives risk being discontinued. Consequently, health care organizations, administrative leaders, and providers need to plan for sustainability from the start. Sustainability-related efforts provide multiple levels of support to the intervention, so that in the event of organizational changes or unexpected barriers, providers and patients can remain optimistic and on-track to reach their equity goals.

One core aspect of long-term sustainability is the ability to adapt a program to changing circumstances. The Roadmap's approach to disparities reduction is not static, and an organization focused on equitable care should continually maintain and improve health equity efforts to ensure long-term effectiveness. Like all quality improvement activities, disparities reduction isn't a one-time effort. It is a process for incorporating equity into a health care organization's day-to-day functioning. Keep in mind that over time, patient populations may change, but maintaining a flexible and dynamic approach to equity will help address those changing circumstances more quickly and effectively.

Of course, an essential component of ensuring the long-term sustainability of a focus on health equity is financial sustainability. Many interventions involve at least a small amount of financial resources to implement, and for organizations with limited resources, sustaining an investment in equity may be difficult. Recent innovations in health policy and payment, however, have demonstrated that policies and payment systems have begun to align with the goal of ensuring health equity. For example, new payment systems like accountable care organizations (ACOs), bundled payments, and global payment arrangements all create financial incentives to invest in the health of a population and focus on health care value, rather than volume. In turn, that focus on population health and value (quality relative to cost) naturally incentivizes health equity: Under new payment models, disparities may be seen as a waste of financial resources, and reducing them could improve an organization's bottom line. For example, interventions that keep people healthy and out of the hospital can result in shared savings for payers and health care organizations.

Too often, equity interventions depend on an initial burst of enthusiasm and the efforts of a dedicated champion; planning for sustainability can keep up the program's momentum, long-term.

Conclusion

Equitable care is vital to the overall health of the nation. Many clinics in the United States serve a racially or ethnically diverse client population—but diversity exists in all patient populations. It is essential to provide equitable care to all patient populations, regardless of the kind of diversity involved. Race, ethnicity, and language are all important areas on which to focus efforts, but so is sexual orientation, gender, religion, geography, income, insurance status, or any other population in which health care quality or outcomes are poor. As such, the implementation of quality improvement efforts that narrow or eliminate disparities—as recommended in the Roadmap to Reduce Disparities—is relevant for any health care organization.

There is no question that tackling health disparities can be a difficult task, but recent developments have demonstrated that progress is being made. The ACA has expanded health care access to millions of minority and low-income patients who never had insurance before. Likewise, ACA provisions surrounding ACOs, patient-centered medical homes, and the collection of REL data, all point toward a broad and comprehensive focus on population health, value-based payment models, and the identification of gaps in care. At the same time, public attention is being focused on health disparities like never before. For example in 2011, the U.S. Department of Health and Human Services released the Action Plan to Reduce Racial and Ethnic Disparities, which advocated for “a nation free of disparities in health and health care.”

Over the course of six steps, the Roadmap has presented a flexible, adaptable approach to incorporating a comprehensive approach to health equity into a quality improvement program. These recommendations have been developed based on lessons learned from the evaluation of 33 minority health interventions, 11 systematic reviews of research focused on reducing disparities, and on-the-ground experience of clinics and quality improvement collaboratives. The lessons presented here can be an effective tool to help health care organizations implement programs and interventions that will help reduce—and hopefully, eliminate—disparities in health care.





Appendix: Best Practices to Reduce Disparities

Finding Answers: Disparities Research for Change

Finding Answers:
Disparities Research for Change



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Practice	Rationale	Possible Strategies	Outcome
Collect and stratify race, ethnicity, and language (REL) data in tandem with other equity efforts	REL data is an important part of reducing disparities, but it is not necessary to put all equity efforts on hold until REL data is available.	Use qualitative methods (e.g., surveys, interviews) to identify disparities if quantitative data isn't available. Continue to foster a culture of equity across the organization while REL data collection is in progress.	Disparities efforts are not stalled. The organization is primed to address disparities once REL-stratified data is available.
Foster a culture of equity	Success is more likely if staff recognize that disparities exist within the organization and view inequality as an injustice that must be redressed. 	Share feedback with providers and incentivize disparities reduction. Include equitable health care as a goal in mission statements. Build a work force that reflects the diversity of the patient population. Institute a Community Advisory Board and develop ties with community-based organizations.	Staff, patients, and community members share a definition of equitable care and value equity in health care delivery. 
Appoint staff and protect their time for equity programs and hold them accountable for results	Without staff time and effort, equity programs are unlikely to reach their full potential.	Include equity goals in job descriptions and performance reviews. Prepare for leadership and staff turn over by cross-training staff and documenting institutional knowledge. Identify equity champions to lead the effort. 	Staff is not overtaxed and remains committed to the program over time.
Target multiple levels and players across the care delivery system 	The causes of disparities are complex; solutions need to address multiple factors.	Avoid focusing exclusively on patients - design programs that intervene with providers, organizations, community groups, and policies, as well as patients.	Programs effectively address the multiple causes of disparities. Improvements are systematic and comprehensive.

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Practice	Rationale	Possible Strategies	Outcome
Identify and appeal to the equity rationale that is most important to your audience	<p>Staff members are motivated for a variety of reasons:</p> <p>Providers are often concerned with maximizing efficiency during the office visit.</p> <p>Front-line staff may be wary of impacting patient flow and room availability.</p> <p>Leadership may respond well to programs that guarantee a positive return on investment and leverage existing resources.</p>	<p>Leverage staff motivation to support a project:</p> <ul style="list-style-type: none"> Enhance the care team and promote care management outside of the clinic. Minimize burden and show respect for staff time. Present data that demonstrate potential for positive financial impact. 	<p>Buy-in across the organization is secured.</p> <p>The intervention is consistently and accurately implemented by all staff.</p>
Involve members of the target population during program planning	<p>Programs that are not culturally targeted risk rejection by patients.</p> <p>Input by minority health workers is not a proxy for patient involvement.</p>	<p>Involve the target population in program design in a manner that is meaningful and inclusive.</p> <p>Engage patients, not just minority health workers.</p>	<p>Community engagement is advanced.</p> <p>Programs are adaptive and effective.</p>
Strike a balance between adherence and adaptability	<p>While adherence to protocol ensures consistency, flexibility is key when working with diverse patients.</p>	<p>Regularly collect process measures, identify opportunities for improvement, and adapt the intervention accordingly.</p> <p>Use standardized checklists to monitor adherence.</p>	<p>Programs are consistent, yet flexible.</p>
Be realistic about the time necessary to move the dial on disparities	<p>Improvements in minority health take time because of multiple challenges inside and outside the clinic.</p>	<p>Plan long-term follow-up to demonstrate statistically significant improvements in health outcomes.</p>	<p>A realistic timeline manages expectations and maintains ongoing support.</p> 